



ESARVHP

New Hampshire Emergency System
for Advance Registration of
Volunteer Healthcare Professionals

ARNP Registration

PLEASE PRINT CLEARLY

Information in RED is REQUIRED. PAGE 1

1. YOUR LICENSE INFORMATION EXACTLY as it appears on your professional license.

First Name _____

Middle Name _____

Last Name _____ Suffix _____

License # _____ State Issuing License _____ Exp. Date (mm/dd/yyyy) _____

2. CONTACT INFORMATION

Mailing Address _____

City _____ State/Zip _____ Country _____

Primary Phone _____ Alternate Phone _____

Email Address _____

3. CONSENTS AND PLEDGES

Do you consent to NH collecting, using and maintaining your personal information? ☐ YES ☐ NO

Do you pledge the information you have provided is correct? ☐ YES ☐ NO

Do you consent to allow the State of NH to perform a background check on you? ☐ YES ☐ NO

4. DEPLOYMENT PREFERENCES

Are you willing to work under the auspices of the Federal Government during a declared national public health emergency?
☐ YES ☐ NO

5. EMERGENCY CONTACT INFORMATION

Emergency Contact Name _____

Emergency Contact Relationship ☐ Spouse ☐ Co-worker ☐ Relative ☐ Friend ☐ Other

Emergency Contact Home Phone _____ Work Phone _____

Email Address _____



ESARVHP

New Hampshire Emergency System
for Advance Registration of
Volunteer Healthcare Professionals

ARNP Registration

Information in RED is REQUIRED. PAGE 2

6. FOREIGN LANGUAGE/SIGNING SKILLS

Language(s) other than English you speak, read and/or write, or sign _____

Language Fluency ☐ Basic ☐ Conversational ☐ Fluent

American Sign Language Fluency ☐ Basic ☐ Conversational ☐ Fluent

7. DISASTER TRAINING

Type of specialized disaster training received _____

Date completed specialized disaster training (mm/dd/yyyy) _____

Training Institution that offered disaster training _____

Date specialized disaster training certification expires, if any (mm/dd/yyyy) _____

8. SPECIALIZED TRAINING YOU HAVE HAD

☐ ACLS ☐ ADLS ☐ BCLS/CPR ☐ BDLS ☐ CCRN ☐ CEN ☐ EMT ☐ EMT: B / I / P

☐ ENPC ☐ First Aid ☐ HAZ-MAT Decon ☐ HEICS ☐ ICS # _____ ☐ NIMS

☐ PALS ☐ Red Cross DSHR # _____ ☐ TNCC ☐ Wilderness First Responder

☐ Military Training (specify) _____

☐ Other Training (specify) _____



ESARVHP

New Hampshire Emergency System
for Advance Registration of
Volunteer Healthcare Professionals

ARNP Registration

Information in RED is REQUIRED. PAGE 3

9. OTHER VOLUNTEER ORGANIZATIONS YOU BELONG TO

☐ American Red Cross

☐ Civil Air Patrol

☐ Community Emergency Response Team

☐ Disaster Behavioral Health Response Team

☐ Disaster Medical Assistance

☐ Medical Response Corps

☐ Military Reserve

☐ National Nurse Response Team

☐ NH Public Health Network

☐ NH Strike Team

☐ State Citizens Corps Council

☐ Other (specify) _____

10. SPECIALTY If several specialties, enter one only.

*Enter information exactly as it appears on specialty certification/registration.

First Name* _____

Middle Name or Initial* _____

Last Name* _____

Title(s)* _____

Organization that awarded specialty certification _____

Area of specialty practice _____

Specialty Certification Number _____ Expiration Date (mm/dd/yyyy) _____

11. HOSPITAL Required to assign ESAR-VHP credential level allowing you to work in a hospital.

Name of hospital where you primarily practice _____

Hospital City, State _____

What specialty do you practice in this hospital? _____



ESAR-VHP

New Hampshire Emergency System
for Advance Registration of
Volunteer Healthcare Professionals

ARNP Registration

Information in RED is REQUIRED. PAGE 4

12. PEER REFERENCE Required to assign ESAR-VHP credential level for those not practicing in a hospital.

Are you a private practitioner, i.e. not currently practicing in a hospital setting? ☐ Yes ☐ No *If No, skip to Clinically Active*

Professional Peer's Name _____

Peer's Email _____

Peer's Phone (eg, 5555555555) _____

Peer's City, State _____

13. CLINICALLY ACTIVE Required to assign ESAR-VHP credential level if not currently practicing in a hospital setting.
* Where you practice in an outpatient or other non-hospital setting

Clinical Supervisor's Name _____

Clinical Supervisor's Email _____

Clinical Supervisor's Phone (eg, 5555555555) _____

Facility Name* _____

Facility City, State* _____

14. RECORD OF ADVERSE ACTIONS

*Are there any adverse actions or restrictions regarding license in any state? ☐ Yes ☐ No

15. DEA REGISTRATION *Enter information exactly as it appears on DEA registration.

First Name* _____

Middle Name or Initial* _____

Last Name* _____

Title(s)* _____

DEA Registration Number _____ Expiration Date (mm/dd/yyyy) _____



ESARVHP

New Hampshire Emergency System
for Advance Registration of
Volunteer Healthcare Professionals

ARNP Registration

Information in RED is REQUIRED. PAGE 5

PRINT & MAIL ALL PAGES OF THIS FORM TO:

Curtis Metzger
Hospital Preparedness, Medical Reserve Corps, & ESAR-VHP Coordinator
NH HOMELAND SECURITY & EMERGENCY MANAGEMENT
33 Hazen Drive
Concord, NH 03305

THANK YOU FOR YOUR WILLINGNESS TO VOLUNTEER!